MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

~63-013190 STATE FILE NUMBER

FILED MAR 21 1963

318 Primary Registration District No. 1003 Registrar's No. 2930

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN: ST LOUIS — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 4215 SANFRANCISCO — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY

c. CITY OR TOWN: ST LOUIS, — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 4215 SANFRANCISCO — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)
First: ELIZABETH — Middle — Last: DE VEYDT

4. DATE OF DEATH Month: MARCH Day: 12 Year: 1963

5. SEX: FEMALE — **6. COLOR OR RACE:** WHITE — **7.** Married ☐ Never Married ☐ Widowed ☒ Divorced ☐ — **8. DATE OF BIRTH:** 6/22/1885 — **9. AGE (last birthday):** 77 — IF UNDER 1 YEAR Months/Days — IF UNDER 24 HR Hours/Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE — **10b. KIND OF BUSINESS OR INDUSTRY** — **11. BIRTHPLACE** (City and state or country): BURMUDA — **12. CITIZEN OF WHAT COUNTRY:** U.S.A.

13a. FATHER'S NAME: ANTON DE VEYDT — **13b. MOTHER'S MAIDEN NAME:** ELIZABETH ELIASON — **14. NAME OF HUSBAND OR WIFE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of): NO — **NO.** — **17. INFORMANT:** 50 EUGENE RAPPLEAN 4215 SANFRANCISCO — **Address**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Left ventricular failure* — INTERVAL BETWEEN ONSET AND DEATH: 1 week

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *Arterio Sclerotic Heart Dicos* 420.0 — 13 yrs

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): *Bronchial Asthma*

PART III. If deceased was female was there a pregnancy in last 90 days? ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ — **20a.** ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **20e. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) — **20f. CITY, TOWN, OR LOCATION** — COUNTY — STATE

21. I attended the deceased from 8-5-62 to 3-12-63 and last saw her alive on 3-11-63 m on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at 12 A

22a. SIGNATURE (Degree or title) — **22b. ADDRESS** 6000 W Florissant — **22c. DATE SIGNED** 3-12-63

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — **23b. DATE:** 3/15/63 — **23c. NAME OF CEMETERY OR CREMATORY:** CALVARY CEMETERY — **23d. LOCATION** (City, town, or county): ST LOUIS MO.

24. FUNERAL DIRECTOR ADDRESS: STROOT — CARROLL 4600 NATURAL BRIDGE — **25. DATE RECD. BY LOCAL REG.:** MAR 13 1963 — **26. REGISTRAR'S SIGNATURE:** Pearl Smith, M.D.

Dr Joost
6000 W. Florissant
ool-7769

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ , Student Embalmer No. _____

working under my personal supervision.

Student _____   Signed _M. W. Rueter_____
        Signature of Student Embalmer

Licensed Embalmer No. 4865

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply
with the above constitutes grounds for revocation of license).
   If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
   If this body is not embalmed, fact should be so stated above.